

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington**

To: Pharmacies
All Prescribers
Managed Care Plans
Nursing Home Administrators

Memorandum No: 04-84 MAA
Issued: December 1, 2004

For More Information, call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Subject: Prescription Drug Program: Washington Preferred Drug List and Expedited Prior Authorization Changes

Effective for claims with dates of service on and after January 1, 2005, the Medical Assistance Administration (MAA) will implement changes to the Washington Preferred Drug List.

Effective the week of January 3, 2005, and after, the Medical Assistance Administration (MAA) will implement the following changes to the Prescription Drug Program:

- Changes to Expedited Prior Authorization Criteria

Therapeutic Drug Class changes to be implemented as part of the Washington Preferred Drug List

Therapeutic Drug Class	Preferred Drugs
Triptans	sumatriptan (all formulations), naratriptan, almotriptan, zolmitriptan (all formulations)
ACE Inhibitors	benazepril (generic products only) captopril (generic products only), enalapril (generic products only), lisinopril (generic products only), Altace [®] (EPA required, no change in code/criteria)
Insulin-release stimulant type oral hypoglycemics	glipizide immediate release (generic products only) glyburide immediate release (generic products only)

Changes to Expedited Prior Authorization Criteria

Drug	Code	Criteria
Plavix® (<i>clopidogrel bisulfate</i>)	116	When used in conjunction with stent placement in coronary arteries. Supply limited to 9 months after stent placement.
	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy.

Miscellaneous Change

MAA removed the following sentence from page F.2 of the billing instructions: “As drugs are added to the Preferred Drug List, their Expedited Prior Authorization (EPA) codes are no longer valid.”

Billing Instructions Replacement Pages

Attached are replacement pages i-ii, v-vi, F.1-F.4, H.7-H.12, and N.1-N.2 for MAA’s current *Prescription Drug Program Billing Instructions*.

How can I get MAA’s provider issuances?

To obtain MAA's provider numbered memoranda and billing instructions, go to MAA’s website at <http://maa.dshs.wa.gov> (click on the Billing Instructions/Numbered Memoranda or Provider Publications/Fee Schedules link).

To request a free hard copy from the Department of Printing:

- **Go to:** <http://www.prt.wa.gov/> (Orders filled daily)
Click on General Store. Follow prompts to Store Lobby → Search by Agency → Department of Social and Health Services → Medical Assistance Administration → desired issuance; **or**
- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-8831/
telephone (360) 570-5024. (Orders may take up to 2 weeks to fill.)

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Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)]

Where do I call to submit change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my hardcopy claims?

Division of Program Support
PO Box 9245
Olympia WA 98507-9245

What is the web site address for pharmacy information?

MAA's Pharmacy Web Site:
<http://maa.dshs.wa.gov/pharmacy/>

How do I find out more about MAA's Prescriptions by Mail program?

Providers Call: 1-888-327-9791
Clients Call: 1-800-903-8369
Or go to MAA's website:
<http://maa.dshs.wa.gov/RxByMail/>

Who do I call for prior authorization?

Pharmacy Prior Authorization Section
Drug Utilization and Review
(800) 848-2842

Backup documentation ONLY must be mailed or faxed to:

Pharmacy Prior Authorization Section
Drug Utilization and Review
PO Box 45506
Olympia WA 98504-5506
Fax (360) 725-2141 (pharmacies)
Fax (360) 725-2122 (prescribers)

Who do I call to begin a Therapeutic Consultation Service (TCS) Review?

Toll Free (866) 246-8504

Who do I contact if I have questions regarding...

Payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
Email: providerinquiry@dshs.wa.gov
or call: (800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Therapeutic Consultation Service (TCS)

[Refer to WAC 388-530-1260]

Overview of TCS

MAA provides a complete drug profile review for each client when a drug claim for that client triggers a TCS consultation. The purpose of TCS is to facilitate the appropriate and cost-effective use of prescription drugs. MAA-designated clinical pharmacists review profiles in consultation with the prescriber or the prescriber's designee by telephone.

TCS occurs when a drug claim exceeds four brand name prescriptions per calendar month.

When a pharmacy provider submits a claim that exceeds the TCS limitations for a client, MAA generates a Point-of-Sale (POS) computer alert to notify the pharmacy provider that a TCS review is required. The computer alert provides a toll-free telephone number (866) 246-8504 to the pharmacy for the prescriber or prescriber's designee to call.

Drugs excluded from the four brand name prescription per calendar month review

Drugs excluded from the four brand name prescription per calendar month review:

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Chemotherapy drugs
- Contraceptives
- HIV medications
- Immunosuppressants
- Hypoglycemia rescue agents
- Generic drugs

What should I do when I get a POS computer alert for a TCS review?

Important Reminders:

- Physicians may have their designee call (866) 246-8504 for TCS consultations.
- Physicians or their designees may call for TCS consultations during the following time periods (Pacific Time):

Monday through Friday	8:00 am to 6:00 pm
Saturday	8:00 am to 1:00 pm
- If the TCS consultation cannot take place because the prescriber or prescriber's designee is unavailable, the pharmacy provider has the option to dispense an emergency supply of the requested drug. (Refer to page C.9 for information on emergency dispensing.)
- Pharmacy staff must call 1-866-246-8504 for authorization to fill prescriptions written by emergency room physicians that trigger the TCS edits. Do not ask emergency room physicians to call TCS.
- Prescribers are requested to provide their DEA numbers to pharmacies.
- Pharmacists must include the MAA provider number or prescriber's DEA on all MAA pharmacy claims.
- Prescriptions for clients residing in skilled nursing facilities are not subject to TCS edits. However, MAA may retrospectively review the clients' drug profiles.

Pharmacy Requirements:

- The pharmacy provider must notify the prescriber that the prescriber or prescriber's designee must call the TCS toll-free telephone number (866) 246-8504 to begin a TCS consultation. Emergency room physicians are not to be contacted; pharmacy staff must call TCS instead.

Prescription Drug Program

Drug	Code	Criteria
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Abilify® 015 All of the following must apply:
(aripiprazole)

- a) There must be an appropriate DSM IV diagnosis; and
- b) Patient is 6 years of age or older.

Accutane®
(isotretinoin)

Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be **absent**:

- a) Paraben sensitivity;
- b) Concomitant etretinate therapy; and
- c) Hepatitis or liver disease.

001 Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.

002 Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.

003 Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.

004 Prevention of skin cancers in patients with xeroderma pigmentosum.

005 Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.

Drug	Code	Criteria
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Adderall® 026 Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
(amphetamine/
dextroamphetamine)

027 Diagnosis of narcolepsy by a neurologist or sleep specialist, following documented positive sleep latency testing and the prescriber is an authorized schedule II prescriber.

087 Depression associated with end stage illness and the prescriber is an authorized schedule II prescriber.

Adderall XR® 094 Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following:
(amphetamine/
dextroamphetamine)

- a) The prescriber is an authorized schedule II prescriber; and
- b) Total daily dose is administered as a single dose.

Adeks® 102 For the treatment of malabsorption conditions, especially those conditions that inhibit the absorption of fat-soluble vitamins (such as cystic fibrosis, steatorrhea, hepatic dysfunction, and cases of HIV/AIDS with malabsorption concern) and all the following:
Multivitamins

- a) Patient is under medical supervision; and
- b) Patient is not taking oral anticoagulants; and
- c) Patient does not have a history of or is not at an increased risk for stroke/thrombosis.

Prescription Drug Program

Drug	Code	Criteria
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Aggrenox® 037 To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and all of the following:

- a) The patient has tried and failed aspirin or dipyridamole alone; and
- b) The patient has no sensitivity to aspirin.

Altace® 020 Patients with a history of cardiovascular disease.
(ramipril)

Ambien® 006 Short-term treatment of insomnia. Drug Therapy is limited to 10 in 30 days, after which the patient must be re-evaluated by the prescriber before therapy can be continued.
(zolpidem tartrate)

Angiotensin Receptor Blockers (ARBs) 092 Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

Atacand® (candesartan cilexetil)
Atacand HCT® (candesartan cilexetil/HCTZ)
Avalide® (irbesartan/HCTZ)
Avapro® (irbesartan)
Benicar® (olmesartan medoxomil)
Cozaar® (losartan potassium)
Diovan® (valsartan)
Diovan HCT® (valsartan/HCTZ)
Hyzaar® (losartan potassium/HCTZ)
Micardis® (telmisartan)
Micardis HCT® (telmisartan/HCTZ)
Teveten® (eprosartan mesylate)
Teveten HCT® (eprosartan mesylate/HCTZ)

Anzemet® 127 Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
(dolasetron mesylate)

Drug	Code	Criteria
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Arava® 034 Treatment of rheumatoid arthritis when prescribed by a rheumatologist at a loading dose of 100mg per day for three days and then up to 20mg daily thereafter.
(leflunomide)

Avinza® 040 Diagnosis of cancer-related pain.
(morphine sulfate)

Calcium w/Vitamin D Tablets 126 Confirmed diagnosis of osteoporosis, osteopenia or osteomalacia.

Clozapine Clozaril® 018 All of the following must apply:

- a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and
- b) Patient is 17 years of age or older; and
- c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.

Concerta® 026 Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
(methylphenidate HCl)

Copegus® 010 Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
(ribavirin)

Dexedrine® See criteria for Adderall®.
(D-amphetamine sulfate)

Dextrostat® See criteria for Adderall®.
(D-amphetamine sulfate)

Prescription Drug Program

Drug	Code	Criteria
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Duragesic® (fentanyl)	040	Diagnosis of cancer-related pain.
Enbrel® (etanercept)	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 25mg subcutaneously twice per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 25mg subcutaneously twice per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.
Fazaclo® (clozapine)	012	All of the following must apply: <ul style="list-style-type: none"> a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 18 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above; and d) Must have tried and failed generic clozapine.
Focalin® (dexamethylphenidate HCl)		See criteria for Concerta®.

Drug	Code	Criteria
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Geodon® (ziprasidone HCl)	046	All of the following must apply: <ul style="list-style-type: none"> a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.
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Note: Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.

Glycolax Powder® (polyethylene glycol)	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Humira Injection® (adalimumab)	028	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every two weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.
Infergen® (interferon alfacon-1)	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.
Intron A® (interferon alpha-2b recombinant)	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminata (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.

Prescription Drug Program

Drug	Code	Criteria
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.
	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.
Kadian® (morphine sulfate)	040	Diagnosis of cancer-related pain.
Kineret Injection® (anakinra)	029	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.
Kytril® (granisetron HCl)	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
Lamisil® (terbinafine HCl)		Treatment of onychomycosis for up to 12 months per nail is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy; <u>or</u>
	045	Fingernail involvement with or without chronic paronychia.
Levorphanol	040	Diagnosis of cancer-related pain.

Drug	Code	Criteria
Lotrel® (amlodipine besylate/benazepril)	038	Treatment of hypertension as a second line agent when blood pressure is not controlled by any: a) ACE inhibitor alone; <u>or</u> b) Calcium channel blocker alone; <u>or</u> c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.
Marinol® (dronabinol)	035	Diagnosis of cachexia associated with AIDS
	036	Diagnosis of cancer and failure of all other drugs to adequately treat nausea and vomiting related to radiation or chemotherapy.
Metadate CD® (methylphenidate HCl)		See criteria for Concerta®.
Miralax® (polyethylene glycol)		See criteria for Glycolax Powder®
Naltrexone		See criteria for ReVia®.
Nephrocaps®	096	Treatment of patients with renal disease.
Nephro-FER® (ferrous fumarate/ folic acid)		
Nephro-Vite® Vitamin B comp W-C)		
Nephro-Vite RX® (folic acid/vitamin B comp W-C)		
Nephro-Vite+FE® (fe fumarate/FA/ vitamin B comp W-C)		
Nephron FA® (fe fumarate/doss/ FA/B comp & C)		

Prescription Drug Program

Drug	Code	Criteria
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Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) 141 An absence of a history of ulcer or gastrointestinal bleeding.

Ansaïd® (flurbiprofen)
 Arthrotec® (diclofenac/misoprostol)
 Bextra® (valdecoxib)
 Cataflam® (diclofenac)
 Celebrex® (celecoxib)
 Clinoril® (sulindac)
 Daypro® (oxaprozin)
 Feldene® (piroxicam)
 Ibuprofen
 Indomethacin
 Lodine®, Lodine XL® (etodolac)
 Meclofenamate
 Mobic® (meloxicam)
 Nalfon® (fenoprofen)
 Naprelan®, Naprosyn® (naproxen)
 Orudis®, Oruvail® (ketoprofen)
 Ponstel® (mefenamic acid)
 Relafen® (nabumetone)
 Tolectin® (tolmetin)
 Toradol® (ketorolac)
 Voltaren® (diclofenac)

Oxandrin® Before any code is allowed, there must be an absence of all of the following:
 (oxandrolone)

- a) Hypercalcemia;
- b) Nephrosis;
- c) Carcinoma of the breast;
- d) Carcinoma of the prostate; and
- e) Pregnancy.

110 Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.

111 To compensate for the protein catabolism due to long-term corticosteroid use.

112 Treatment of bone pain due to osteoporosis.

Drug	Code	Criteria
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OxyContin® 040 Diagnosis of cancer-related pain.
 (oxycodone HCl)

Parcopa® 049 Diagnosis of Parkinson's disease and one of the following:

- a) Must have tried and failed generic carbidopa/levodopa; or
- b) Be unable to swallow solid oral dosage forms.

PEG-Intron® 109 Treatment of chronic hepatitis C in patients 18 years of age or older.
 (peginterferon alpha 2b)

Pegasys® 109 Treatment of chronic hepatitis C in patients 18 years of age or older.
 (peginterferon alpha-2a)

Plavix® 116 **When used in conjunction with stent placement in coronary arteries. Supply limited to 9 months after stent placement.**
 (clopidogrel bisulfate)

136 For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy.

Pravachol® 039 Patient has a clinical drug-drug interaction with other statin-type cholesterol-lowering agents.
 (pravastatin sodium)

Pulmozyme® 053 Diagnosis of cystic fibrosis and the patient is 5 years of age or older.
 (dornase alpha)

Rebetol® See criteria for Copegus®.
 (ribavirin)

Rebetron® 008 Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
 (ribavirin/interferon alpha-2b, recombinant)

009 Treatment of chronic hepatitis C in patients with compensated liver disease.

Prescription Drug Program

Drug	Code	Criteria
Remicade Injection® (<i>infliximab</i>)	022	Treatment of rheumatoid arthritis in combination with methotrexate when prescribed by a rheumatologist in those patients who have had an inadequate response to methotrexate alone.
	023	Treatment of Crohn's disease when prescribed by a gastroenterologist in those patients who have tried and failed conventional therapy.
Rena-Vite® Rena-Vite RX® (<i>folic acid/vit B comp W-C</i>)	096	Treatment of patients with renal disease.
ReVia® (<i>naltrexone HCl</i>)	067	<p>Diagnosis of past opioid dependency or current alcohol dependency.</p> <p>Must be used as adjunctive treatment within a state-certified chemical dependency treatment program. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following:</p> <ul style="list-style-type: none"> a) Acute liver disease; and b) Liver failure; and c) Pregnancy.



Note: A ReVia® (Naltrexone) Authorization Form [DSHS 13-677] must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:**
<http://www1.dshs.wa.gov/msa/forms/eforms.html>

Drug	Code	Criteria
Risperdal® (<i>risperidone</i>)	054	<p>All of the following must apply:</p> <ul style="list-style-type: none"> a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.
Ritalin LA® (<i>methylphenidate HCl</i>)		See criteria for Concerta®.
Roferon-A® (<i>interferon alpha-2a recombinant</i>)	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
Seroquel® (<i>quetiapine fumarate</i>)		See criteria for Risperdal®.
Sonata® (<i>zaleplon</i>)		See criteria for Ambien®.
Soriatane® (<i>acitretin</i>)	064	<p>Treatment of severe, recalcitrant psoriasis in patients 16 years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an absence of all of the following:</p> <ul style="list-style-type: none"> a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.

Ribavirin See criteria for Copegus®.

Preferred Drug List

MAA, in coordination with the Health Care Agency (HCA) and Labor & Industries (L & I), have developed a list of preferred drugs within a selected therapeutic class that are selected based on clinical evidence of safety, efficacy, and effectiveness.

Drug Class	Preferred Drug(s)
ACE Inhibitors	benazepril (generic products only) captopril (generic products only) enalapril (generic products only) Lisinopril [®] (generic products only) Altace [®] (*EPA required)
Beta Blockers	All generics: acebutolol, atenolol, betaxolol, bisoprolol, labetalol, metoprolol, nadolol, propranolol, propranolol ER, pindolol, timolol. Toprol XL [®] (*EPA required)
Calcium Channel Blockers	verapamil verapamil SA/SR/ER/24H diltiazem diltiazem ER/XR/CR/SR nifedipine ER/SA/XL Norvasc [®]
Estrogens	estradiol oral tablets (generic products only) Menest [®] oral tablets Premarin [®] vaginal cream
Histamine-2 Receptor Antagonist (H2RA) (*Not subject to TIP. See pg. M.1.)	ranitidine (generic products only)
Long-Acting Opioids (oral tabs/caps/liquids) (*Not subject to TIP. See pg. M.1.)	methadone morphine sulfate SA Website Only Update effective 1/1/05

Prescription Drug Program

Drug Class	Preferred Drug(s)
Non-Sedating Antihistamines (*Not subject to TIP. See pg. M.1.)	All loratadine or loratadine/pseudoephedrine OTC products (prescription products are non-preferred)
NSAIDs (oral)	All generics: diclofenac sodium, diclofenac potassium, etodolac, etodolac ER/XL, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac, meclofenamate, nabumetone, naproxen, naproxen sodium, oxaprozin, piroxicam, sulindac, and tolmetin. (<i>generics still require EPA – must not have history of GI bleeding</i>)
Insulin-release stimulant type oral hypoglycemics	glipizide immediate release (generic products only) glyburide immediate release (generic products only)
Proton Pump Inhibitors (PPIs)	Protonix [®] OTC Prilosec [®]
Skeletal Muscle Relaxants	baclofen (generic products only), cyclobenzaprine (generic products only), methocarbamol (generic products only)
Statin-type cholesterol-lowering agents	lovastatin (generic products only) Lipitor [®] Pravachol [®] (*EPA required) Website Only Update effective 1/1/05
Triptans	Imitrex [®] (all formulations) Amerge [®] Axert [®] Zomig [®] (all formulations)
Urinary Incontinence	oxybutynin (generic products only)